MDR Tracking Number: M2-03-1176-01
IRO Certificate # 5259

July 9, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
Claimant is a 58-year-old female injured on ___. The records indicate that she was injured when she fell down stairs while at work and then fell approximately six steps. She apparently sustained injury to her left hip and lumbar region as well as striking her head resulting in a laceration to the top of her head. She was taken to a local emergency room and had sutures to her scalp and work-up including CT scan of the brain to rule out intracranial injury. She was diagnosed with evidence of neck strain and post-concussion syndrome as well as evidence of post-traumatic headaches. She received extensive conservative care including pain management program. While in the post-pain management program, she utilized an RS Muscle Stimulator, the stimulator reduced her pain by 50% and reduced the use of her oral analgesic medications based on the records reviewed.

REQUESTED SERVICE (S)
RS Muscle Stimulator, 4-channel for purchase.

DECISION
Physician approved.

RATIONALE/BASIS FOR DECISION

In my review of the medical records, there was clear evidence of injury resulting in chronic pain and spasm in the cervical region from her work-related accident. The records clearly indicated that the neck and head were injured in the fall and the records reflect that this individual received an aggressive and long-term care for her recurrence and recalcitrant pain in the neck. The records reflect an appropriate and extensive work-up including CT scan of the neck and brain as well as MRI of the neck. There was no evidence of surgical disease. She was treated with medications orally and maximized her care and started on an RS Muscle Stimulator. The use of the stimulator was well documented in the records as being regular and daily. The effects of the use of the stimulator were well documented in the records and indicated a reduction in pain and as a result of use of this stimulator there is a reduction in the use of oral analgesics. The individual's pain was so severe that it required participation of multiple pain management programs and using the RS Muscle Stimulator was a component of that pain program to help her learn to reduce her pain, increase her function and limit her use of oral analgesics. The advice was medically necessary and appropriate for chronic pain control as it has been proven in this case to increase her function, reduce her dependence on oral analgesic narcotics, and has been displayed to be utilized by this individual to maintain her function and she has demonstrated regular and beneficial use of this device. For this reason, I recommend that this purchase was medically reasonable and appropriate.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 11th day of July 2003.